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United States
Department of Defense



DoD Needs to Improve the Billing System for Health
Care Provided to Contractors at Medical Treatment
Facilities in Southwest Asia

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Acronyms and Abbreviations

ASD(HA)	Assistant Secretary of Defense (Health Affairs)
DFAS	Defense Finance and Accounting Service
DoDI	Department of Defense Instruction
DoD OIG	Department of Defense Office of Inspector General
MTF	Medical Treatment Facility
SPOT	Synchronized Predeployment and Operational Tracker
TMDS	Theater Medical Data Store
USD(AT&L)	Under Secretary of Defense for Acquisition, Technology, and Logistics
USD(C)/CFO	Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD
USD(P&R)	Under Secretary of Defense for Personnel and Readiness
USCENTCOM	U.S. Central Command



INSPECTOR GENERAL
DEPARTMENT OF DEFENSE
4800 MARK CENTER DRIVE
ALEXANDRIA, VIRGINIA 22350-1500

June 27, 2012

MEMORANDUM FOR DISTRIBUTION

SUBJECT: DoD Needs to Improve the Billing System for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia (Report No. DODIG-2012-106)

We are providing this report for review and comment. In April 2011, DoD implemented a billing system for health care provided to contractor personnel at medical treatment facilities in Southwest Asia; however, the system needs improvement. We considered management comments on a draft of this report when preparing the final report.

DoD Directive 7650.3 requires that all recommendations be resolved promptly. Comments from the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, were partially responsive. We request that the Under Secretary comment on Recommendations B.2.a and B.2.b.i by July 27, 2012.

Please provide comments that conform to the requirements of DoD Directive 7650.3. If possible, send a portable document format (.pdf) file containing your comments to audyorktown@dodig.mil. Copies of your comments must have the actual signature of the authorizing official for your organization. We are unable to accept the /Signed/ symbol in place of the actual signature. If you arrange to send classified comments electronically, you must send them over the SECRET Internet Protocol Router Network (SIPRNET).

We appreciate the courtesies extended to the staff. Please direct questions to me at (703) 604-8866 (DSN 664-8866).

A handwritten signature in blue ink, reading "Alice F. Carey", is positioned above the typed name.

Alice F. Carey
Assistant Inspector General
Readiness, Operations, and Support

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Results in Brief: DoD Needs to Improve the Billing System for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia

What We Did

The previous Commander, U.S. Central Command, requested this audit. Our objective was to follow up on the Department of Defense Office of Inspector General Report No. D-2009-078, "Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia," May 4, 2009.

What We Found

In April 2011, DoD began billing contractors for health care provided in Southwest Asia; however, improvements to the billing system are needed. DoD officials took more than 5 years from the issuance of DoD guidance that required contractor reimbursement for health care to develop and implement a billing system. This occurred because the working group designated the Defense Finance and Accounting Service (DFAS) to perform billing, but the group did not assign a functional proponent to oversee the billing system. As a result, DoD did not bill contractors for at least \$8.1 million in health care expenses for FY 2010. This estimate does not include missed opportunities to bill contractors for health care between FY 2006, when DoD issued guidance, and FY 2009.

Also, DoD Components experienced data reliability problems that affected the accuracy of the bills, totaling \$84,116, for contractor health care provided in February 2011. This occurred because the DoD working group decided to use two nonfinancial databases that were not intended for billing and staff at medical treatment facilities in Southwest Asia and contractor personnel made data input errors. As a result, DoD underbilled contractors for health care provided in February 2011 by at least \$128,850. Without improvements to the billing

process, it is likely that DFAS will continue to underbill.

What We Recommend

We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, chair a meeting with the Under Secretary of Defense for Acquisition, Technology, and Logistics and the Under Secretary of Defense for Personnel and Readiness to assign a DoD functional proponent for billing contractors for health care.

We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, in coordination with the DoD working group and the proponent, establish controls to correct the problems that we identified; review the current billing system for accuracy; and bill for health care provided to contractor personnel before February 2011 and amounts underbilled in 2011.

Management Comments and Our Response

Comments from the Deputy Comptroller for Program/Budget were responsive or partially responsive to the recommendations. DFAS billed for health care provided to contractor personnel before February 2011. Comments from the Assistant Secretary of Defense for Logistics and Materiel Readiness and the Chief Financial Officer for the Assistant Secretary of Defense (Health Affairs) were responsive.

We request the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, provide additional comments on the final report by July 27, 2012. Please see the recommendations table on the back of this page.

Recommendations Table

Management	Recommendations Requiring Comment	No Additional Comments Required
Under Secretary of Defense for Acquisition, Technology, and Logistics		A.1, B.1
Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD	B.2.a, B.2.b.i	A.1, A.2, B.2.b.ii, B.2.c, B.2.d
Under Secretary of Defense for Personnel and Readiness		A.1
Assistant Secretary of Defense (Health Affairs)		B.3.a, B.3.b

Please provide comments by July 27, 2012.

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Introduction

Objective

Our objective was to follow up on the Department of Defense Office of Inspector General (DoD OIG) Report No. D-2009-078, “Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia,” May 4, 2009. Specifically, we reviewed the status of billing contractors for health care provided at medical treatment facilities (MTFs) in Southwest Asia. See Appendix A for the scope and methodology. The previous Commander, U.S. Central Command (USCENTCOM), requested this audit (see Appendix B).

Background

The U.S. Government used thousands of contractor personnel in USCENTCOM’s area of responsibility. Contractor personnel performed a variety of contracted services, such as base support, security, training, construction, interpreter, and transportation. At times, contractor personnel in Southwest Asia required medical services provided at DoD’s MTFs.

Public Law 107-107, “National Defense Authorization Act For Fiscal Year 2002,” Section 1079b, “Procedures for Charging Fees for Care Provided to Civilians; Retention and Use of Fees Collected,” December 28, 2001, requires the Secretary of Defense to implement procedures so that an MTF may charge civilians who are not covered beneficiaries or their insurers for the cost of health care. Public Law 107-107 allows the MTF to retain and use the fees collected.

Figure 1. Entrance to Main Hospital in Kandahar, Afghanistan



Source: DoD OIG auditor, February 9, 2011

DoD Instruction (DoDI) 3020.41, “Contractor Personnel Authorized to Accompany the U.S. Armed Forces,” October 3, 2005,¹ states that DoD may provide resuscitative care, stabilization, hospitalization, and assistance with patient movement in emergencies where loss of life, limb, or eyesight could occur. Primary medical or dental care is not authorized, and contractor personnel may not receive these services at MTFs unless specifically authorized under the terms of the contract and noted on the letter of authorization. All costs associated with medical care are reimbursable to the U.S.

¹ On December 20, 2011, the Acting Under Secretary of Defense for Acquisition, Technology, and Logistics reissued DoDI 3020.41 with the title, “Operational Contract Support (OCS).” However, the policy for contractor personnel receiving reimbursable health care from MTFs did not change.

Government and are the responsibility of the contractor personnel, their employers, or their health insurance providers.

In July 2006, USCENTCOM issued Fragmentary Order 09-1038, “Contractor Care in the USCENTCOM AOR [Area of Responsibility],” which established guidance in accordance with DoDI 3020.41. The fragmentary order states, “USCENTCOM will work with the Joint Staff and OSD [Office of the Secretary of Defense] to establish a billing mechanism utilizing the OSD established outpatient and inpatient rates for contingency operations as a basis for billing.”

On January 4, 2007, the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD (USD[C]/CFO), issued a memorandum establishing medical billing rates for contractor personnel deployed with U.S. Armed Forces. This and subsequent memorandums require the contractor to provide a letter of authorization from the contracting officer that states the level of health care authorized and the entity responsible for payment of the bill. USD(C)/CFO personnel revised the medical billing rates on June 16, 2008; September 1, 2009; December 30, 2010; and March 29, 2012.

On September 15, 2010, USCENTCOM personnel issued an update to their Fragmentary Order 09-1038, stating that contractor personnel must be registered correctly in the electronic medical record to facilitate reimbursement from the contractor. The update states that billing for care provided to contractor personnel is not the responsibility of the medics in Southwest Asia and will be accomplished outside of the USCENTCOM area of responsibility. The update does not provide any other details on how contractor billing will occur.

Figure 2. DoD Medical Personnel Providing Care in Kandahar, Afghanistan



Source: U.S. Navy, December 20, 2010

Previous Report Identified Need to Bill Contractors for Health Care

DoD OIG Report No. D-2009-078 identified that MTFs were not billing contractors for health care provided. In November 2008, DoD officials from various organizations established a working group, which was chaired by the USD(C)/CFO, to discuss how to implement a billing system in contingency operations like Iraq and Afghanistan. In the report, we recommended that the USD(C)/CFO continue to chair the working group with officials from the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD[AT&L]); USCENTCOM; the Assistant Secretary of Defense (Health Affairs) (ASD[HA]); the Defense Finance and Accounting Service (DFAS); the Joint Staff; and the Military Departments. As part of our recommendation, we stated that the working

group should, at a minimum, designate a DoD functional proponent² for this issue; establish clearly defined roles and responsibilities for implementing a billing system; and determine which DoD Component would perform the billing. On April 2, 2009, the USD(C)/CFO agreed with our recommendation to continue to chair the working group and seek a solution for this billing challenge.

Review of Internal Controls

DoD Instruction 5010.40, “Managers’ Internal Control Program (MICP) Procedures,” July 29, 2010, requires DoD organizations to establish a management internal control program to identify and promptly correct ineffective internal controls and establish internal controls when warranted. Although DoD implemented a billing system in April 2011, DoD did not implement a system that accurately billed contractors for health care provided at MTFs in Southwest Asia. See Finding B for details of the internal control weakness. We will provide a copy of the report to the senior official responsible for internal controls in the USD(AT&L), USD(C)/CFO, and ASD(HA).

²DoDI 5010.40, “Managers’ Internal Control Program (MICP) Procedures,” July 29, 2010, defines a DoD functional proponent as a DoD staff principal responsible for policy and oversight of a particular functional area.

Finding A. DoD Delayed Billing Contractors for Health Care Provided in Southwest Asia

DoD officials took more than 5 years from the issuance of DoD guidance that required contractor reimbursement for health care to develop and implement a billing system. This occurred because the working group (officials from the USD[C]/CFO, the USD[AT&L], USCENTCOM, the ASD[HA], DFAS, the Joint Staff, and the Military Departments) designated DFAS to perform billing, but the group did not assign a functional proponent to oversee the billing system. As a result, DoD did not bill contractors for at least \$8.1 million in health care expenses for FY 2010. This estimate does not include missed opportunities to bill contractors for health care between FY 2006, when DoD issued guidance, and FY 2009.³

DoD Officials Took More Than 5 Years to Develop and Implement a System for Billing Contractors

In October 2005, DoD issued DoDI 3020.41, which states that all costs associated with treatment of contingency contractors are reimbursable to the Government; however, DoD officials took 5 years and 6 months to implement a billing system. DoD OIG Report No. D-2009-078 acknowledged that more than 3 years after the DoDI was issued, DoD did not bill contractors for health care provided in Southwest Asia and recommended that DoD implement a billing system that was practical for USCENTCOM. However, the DoD working group, established in November 2008, took 29 months to implement a billing system. On April 29, 2011, DoD began billing for health care provided by MTFs to contractors in Southwest Asia during February 2011.

The working group (established during our initial audit) began meeting in November 2008 to develop a concept for billing contractors. An official from USD(C)/CFO provided brief summaries of each action taken by the working group since October 20, 2009. According to the working group summaries, most of the group's interactions were between various officials from the USD(C)/CFO and DFAS. However, on May 20, 2010, one working group meeting included senior officials from the offices of the USD(C)/CFO, the ASD(HA), the Assistant Secretary of the Air Force (Financial Management and Comptroller), the Assistant Secretary of the Army (Financial Management and Comptroller), Air Force Surgeon General, and the Joint Staff Surgeon. The group held this meeting to provide an overview of a billing concept.

The working group asked the Military Departments to provide their position on the billing concept. The Military Departments recommended that DFAS institute a process on their behalf. The USD(C)/CFO verbally approved the billing concept on September 29, 2010, according to the summaries of the working group actions. In the spring of 2011, officials from the Deputy Assistant Secretary of Air Force (Budget), the Assistant Secretary of Navy (Financial Management and Comptroller), and the U.S.

³ Please refer to Appendix C for details on statistical projections.

Army Financial Management Command signed memorandums of agreement with DFAS and authorized DFAS to bill on their behalf. However, the working group did not assign, and no one accepted responsibility as, the DoD functional proponent for overseeing the billing system.

A DoD Functional Proponent to Oversee the Billing System Is Needed

The delay in implementing a billing system occurred because the DoD working group did not designate a DoD functional proponent with defined roles and responsibilities to oversee the system for billing contractors. When we asked a USD(C)/CFO official in January 2011 which senior DoD official within OSD was principally responsible, the official told us that this issue was still open. On March 30, 2011, a USD(AT&L) official

As a result, no DoD Component made it a priority to implement a billing system in a timely manner.

stated that responsibilities for establishing a billing system for contractor health care provided in a contingency operation would be addressed in an updated version of

DoDI 3020.41. On May 6, 2011, an official

from the Uniform Business Office, a department within ASD(HA), stated that other than assisting the USD(C)/CFO in developing billing rates, ASD(HA) was not responsible for developing policy for “non-fixed facilities,” which they consider all the MTFs in Southwest Asia to be. Consequently, no DoD Component had officially accepted responsibility for overseeing a contractor health care billing system in Southwest Asia. As a result, no DoD Component made it a priority to implement a billing system in a timely manner.

On December 20, 2011, USD(AT&L) reissued DoDI 3020.41. The reissued DoDI assigns the USD(C)/CFO with the responsibility for developing policy addressing the reimbursement of funds for health care provided to contractors in contingency operations. However, the Instruction does not assign specific roles and responsibilities for oversight of the billing process.

Because neither the DoD working group nor the reissued DoDI 3020.41 assign a DoD functional proponent responsible for oversight, we are elevating this issue to the Under Secretary level. The USD(C)/CFO should chair a meeting with the USD(AT&L) and the Under Secretary of Defense for Personnel and Readiness (USD[P&R])⁴ to select a DoD functional proponent responsible for oversight of the system established for billing for health care provided to contractor personnel authorized to accompany U.S. Armed Forces in contingency operations.

⁴ The ASD(HA) reports directly to the USD(P&R).

Estimate of Claims Not Billed for Health Care Provided to Contractors in Southwest Asia

MTFs in Southwest Asia provided care to contractors through January 2011 without seeking reimbursement. On January 6, 2012, a USD(C)/CFO official stated that DFAS

We estimate DoD did not bill contractors for at least \$8.1 million in health care expenses for FY 2010.

planned to bill for contractor health care provided in Southwest Asia before February 2011. We estimate DoD did not bill contractors for at least

\$8.1 million in health care expenses for FY 2010.⁵ DoD should bill contractors that received health care before February 2011. Billing for health care provided by MTFs to contractors would provide additional resources to support the troops.

Recommendations, Management Comments, and Our Response

A.1. We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, chair a meeting with the Under Secretary of Defense for Acquisition, Technology, and Logistics and the Under Secretary of Defense for Personnel and Readiness to select a DoD functional proponent responsible for overseeing the billing system for health care provided to contractor personnel authorized to accompany U.S. Armed Forces in contingency operations.

Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, Comments

The Deputy Comptroller for Program/Budget provided comments for USD(C)/CFO. He partially agreed and stated that the DoD working group planned to assign oversight responsibilities at DoD's upcoming Program and Budget Review. Further, he stated that DFAS continued to serve as the functional proponent for DoD accounting and billing functions.

Under Secretary of Defense for Acquisition, Technology, and Logistics Comments

The Assistant Secretary of Defense (Logistics and Materiel Readiness) provided comments for USD(AT&L). He agreed and stated that a single DoD Component for overseeing the billing process was necessary and that DFAS was serving as the functional proponent for accounting and billing functions. Further, he stated that the DoD working group would continue to review roles and responsibilities associated with the medical billing system process for in-theater health care provided to contractor personnel and would assign specific oversight responsibilities to the most appropriate DoD Component.

⁵ See Appendix C, "Estimate of Claims Not Billed for Contractor Health Care," for more details on our interpretation of the statistical projection for FY 2010. This estimate does not include billings before and after FY 2010.

Under Secretary of Defense for Personnel and Readiness Comments

The Chief Financial Officer for ASD(HA) provided comments for USD(P&R). He agreed and stated that the working group planned to assign oversight responsibilities at the upcoming Program and Budget Review.

Our Response

Comments from the Assistant Secretary of Defense (Logistics and Materiel Readiness); Deputy Comptroller; and Chief Financial Officer, ASD(HA), were responsive, pending the assignment of specific responsibilities for oversight of the billing process during the upcoming Program and Budget Review. If the working group does not designate a DoD functional proponent during the upcoming Program and Budget Review, we will elevate this decision to the Under Secretary of Defense level. At this time, we do not require additional comments.

A.2. We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, in coordination with the proponent selected in response to Recommendation A.1., bill contractors for health care provided in Southwest Asia before February 2011.

Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, Comments

The Deputy Comptroller agreed and stated that DFAS has billed for health care encounters as far back as FY 2007 and continued to address data reliability programs for additional billings. DFAS was continuing to work with USD(AT&L) and ASD(HA) officials to improve the billing process. Specifically, the Deputy Comptroller stated that changes were “made to improve the Synchronized Predeployment and Operational Tracker (SPOT) query process by 10 percent to include identifying contracts whether or not they have a task order associated with them; running queries on all active, open or closed SPOT deployments; and opening up the query to include Social Security Number (SSN, Last Name/First Name, and Date of Birth).”

However, the Deputy Comptroller disagreed with our estimate of at least \$8.1 million in health care expenses for FY 2010. He stated that DFAS had billed \$4.2 million in FY 2010 contractor health care encounters and that DFAS continued to review data to determine whether additional billings were required.”

Our Response

Although the Deputy Comptroller disagreed with our estimate of \$8.1 million, we consider his comments responsive because DFAS implemented the recommendation to bill for prior years. On May 24, 2012, a DFAS official provided us documentation that DFAS had billed \$13.7 million for health care going back to FY 2007. The difference between our estimate and the amount the Deputy Comptroller stated DFAS billed for FY 2010 may be attributed to several factors. Our \$8.1 million estimate for contractor health care expenses was based on a statistical projection and included additional audit

work to resolve data integrity issues discussed in Finding B. Based on ASD(HA) comments to Recommendation B.3 we conclude that DFAS did not bill for all FY 2010 contractor medical encounters because they are continuing to address these issues for additional billings. Therefore, no additional comments were required.

We commend USD(C)/CFO and DFAS personnel for aggressively pursuing the reimbursement of health care provided by MTFs to contractors in Southwest Asia. Because improvements continue to be made to the billing process, the amount billed will likely continue to increase.

Finding B. Billing System for Health Care Provided to Contractors in Southwest Asia Needs Improvement

DoD Components experienced data reliability problems that affected the accuracy of the bills, totaling \$84,116, for contractor health care provided in February 2011. This occurred because the DoD working group decided to use two nonfinancial databases that were not intended for billing and staff at MTFs in Southwest Asia and contractor personnel made data input errors. As a result, DoD underbilled contractors for health care provided in February 2011 by at least \$128,850. Without improvements to the billing process, it is likely that DFAS will continue to underbill.

Data Reliability Problems With Billing System Occurred

Our review of the billing system before its implementation identified problems with data reliability. Although DFAS personnel attempted to correct the problems within their control before implementing the system, the billings for February 2011 showed that not all problems were fixed and that additional problems occurred.

According to DFAS officials, DoD's billing system relied on two databases: the Theater Medical Data Store (TMDS)⁶ managed by the ASD(HA), for identifying health care provided to contractors and the Synchronized Predeployment and Operational Tracker (SPOT),⁷ managed by the USD(AT&L), for identifying the contractor organization's contract number. TMDS has a data field for identifying the patient as contractor personnel. An official from ASD(HA) provided DFAS with a spreadsheet from TMDS of patients who were recorded as contractor personnel. A DFAS official stated that DFAS personnel would use spreadsheets from the SPOT database to identify the contract number under which the contractor personnel worked, primarily by matching the patient's social security number in the two databases. Further, from the contract number, DFAS personnel determined which contractor organization should be billed for the employee's medical treatment. Then, DFAS personnel billed the contractor organization and sent funds collected to the Military Departments. However, several problems existed concerning the reliability of the data that DFAS personnel used to bill contractors.

Problems With Data Reliability of Two Databases Chosen

In March 2011, before the implementation of the billing system, we identified data reliability problems that could negatively affect billing contractors for health care for FY 2010.

⁶ TMDS serves as the Southwest Asia database for collecting, distributing, and viewing medical information in theater. It provides one central location for health care providers to view Southwest Asia medical data.

⁷ SPOT is the Joint Enterprise contractor management and accountability system that provides a central source of contingency contractor information. Contractor companies are required to maintain by name accountability within SPOT while Government representatives use SPOT for oversight of the contractors they deploy.

Specifically, the following reliability problems existed:

- 3,499 or 28 percent of the medical encounters in the spreadsheet from TMDS had errors that could affect billing,
- 11,019 contractor medical encounters were not included in the spreadsheet from TMDS, and
- 5,285 or 45 percent of the medical encounters had missing and incomplete contractor profiles in SPOT.⁸

On March 30, 2011, we shared our concerns regarding the data reliability of the two databases with officials from the USD(AT&L), USD(C)/CFO, ASD(HA), the Military Department Surgeons General, and DFAS. DFAS personnel stated they were developing business rules for the billing system and requested that we review the business rules before DFAS initiated the billing system.

On April 11, 2011, DFAS personnel provided updated business rules intended to address the issues that we identified. We questioned whether the new rules would correct all of the deficiencies; however, DFAS personnel did not provide feedback to our questions before implementing the billing system. On April 29, 2011, DFAS personnel began billing contractors for health care provided by MTFs in Southwest Asia. DFAS personnel billed contractors \$84,116 for 110 medical encounters that occurred during February 2011.

DFAS Personnel Underbilled Contractors for Health Care Provided in February 2011

DFAS personnel underbilled for health care provided to contractor personnel during February 2011 by at least \$128,850. Based on the billings, it appeared that DFAS corrected some of the problems identified in our review before implementing the billing system. However, problems still existed. See the table on the next page for the breakout of the problems identified in the implemented billing system and the dollar value underbilled.

⁸ Please refer to Appendix C for details on statistical projections.

Table. Problems That Resulted in DFAS Underbilling Contractors for Health Care Provided in February 2011

Problems That Resulted in Underbilling	Amount Underbilled
Length of Stay Errors in the TMDS Spreadsheet	\$62,950
Contractor Medical Encounters Not Included in the TMDS Spreadsheet	10,586
Missing and Incomplete Contractor Profiles in SPOT	33,838
Health Care Provided to Contractors Working Under Non-DoD Contracts*	21,476
Total	\$128,850
* Although not a data reliability problem, we identified this issue during our review of the February 2011 contractor medical encounters in Southwest Asia.	

Length of Stay Errors in the TMDS Spreadsheet

DFAS personnel did not consistently bill the correct length of stay for the February 2011 inpatient medical encounters, which resulted in at least \$62,950 in underbillings. The TMDS spreadsheet that ASD(HA) provided to DFAS contained discharge date discrepancies when matched with the patient’s electronic medical record. Of 26 inpatient stays during February 2011, 22 did not have discharge dates recorded in the TMDS spreadsheet. For those inpatient stays with no discharge date, DFAS personnel billed 11 encounters for only 1 day although the patients’ medical records indicated hospital stays for multiple days. For example, DFAS personnel billed:

- a patient treated for an intestinal disorder for 1 day (\$2,518); however, the bill should have been for 8 days (\$20,144);
- a patient treated for inflammation of the gallbladder for 1 day (\$2,518); however, the bill should have been for 4 days (\$10,072); and
- a patient treated for a brain hemorrhage (non-battle-related) for 1 day (\$2,518); however, the bill should have been for 6 days (\$15,108).

Using the per diem rate of \$2,518 per inpatient day, for these 11 inpatient stays, DFAS personnel billed \$27,698, but should have billed \$90,648.

Contractor Medical Encounters Not in the TMDS Spreadsheet

The TMDS spreadsheet provided by ASD(HA) for contractor medical encounters during February 2011 did not include some contractor medical encounters that resulted in at least \$10,586 in underbillings. An official from ASD(HA) provided DFAS with a TMDS spreadsheet that contained medical encounters for three patient categories.⁹ The TMDS

⁹ The TMDS spreadsheet contained medical encounters for patients recorded in the patient category as “A03 [Contractor],” “K65 [Other beneficiaries of U.S. Govt. Contract Employee],” and “K99 [Patient not elsewhere classified].”

spreadsheet did not include medical encounters when the patient category was blank or other potential contractor medical encounters that staff at the MTF did not record as contractor encounters. Therefore, DoD missed opportunities to bill contractors—not identified in TMDS as contractor personnel—who received health care at MTFs in Southwest Asia in February 2011. For example,

- Staff at an MTF treated a patient for bronchitis. DFAS personnel should have billed \$222 for one outpatient visit. The patient category in the medical record was “Army Retiree Length of Service” and the patient was not in the TMDS spreadsheet DFAS used for billing. However, this patient was also a contractor.
- Staff at an MTF treated a patient for joint pain and skin rash. DFAS personnel should have billed \$444 for two outpatient visits. The patient category in the medical record was blank, and the patient was not in the TMDS spreadsheet DFAS used for billing. However, this patient was a contractor.

If staff at the MTFs did not select contractor as the patient category when recording contractor medical encounters, then these encounters were not included in the TMDS spreadsheet provided to DFAS for billing.

Missing and Incomplete Contractor Profiles in SPOT

DFAS personnel were not able to trace 145 of the 251 patients in the TMDS spreadsheet to SPOT with a contract number for health care provided in February 2011. Of the 145 patients not traced to SPOT, 37 patients actually did have a contract number in SPOT, but the SPOT spreadsheet used for billing did not include the contract number. For example,

- DFAS personnel should have billed a patient admitted following a fall for 2 days (\$5,036). Although the TMDS spreadsheet included the inpatient stay, the SPOT spreadsheet showed no profile. As a result, DFAS personnel could not bill for the medical care. On June 27, 2011, we queried the patient’s name in SPOT and found the patient’s SPOT profile and contract number.
- DFAS personnel should have billed a patient admitted for the treatment of a seizure for 1 day (\$2,518). Although the TMDS spreadsheet included the inpatient stay, the SPOT spreadsheet showed no profile. As a result, DFAS personnel could not bill for the medical care. On May 20, 2011, we queried the patient’s name in SPOT and found the patient’s SPOT profile and contract number.

For the 37 patients that actually did have a contract number in SPOT, DFAS personnel should have billed an additional \$33,838 for health care provided in February 2011. Data were not available in SPOT to bill the remaining 108 patients.

Health Care Provided to Contractors Working Under Non-DoD Contracts

In addition to the data reliability issues, DFAS personnel did not bill nine medical encounters for contractor personnel that were working under non-DoD contracts—U.S. Department of State and General Services Administration contracts. For example,

- DFAS personnel should have billed a patient admitted for the treatment of chest pain for 5 days (\$12,590). The patient was working under a General Services Administration contract.
- DFAS personnel should have billed a patient admitted for the treatment of a gunshot wound to the finger for 1 day (\$2,518). The patient was working under a U.S. Department of State contract.

Figure 3. U.S. Air Force Doctor Providing Care in Bagram Air Base, Afghanistan



Source: U.S. Air Force, March 9, 2007

Although DFAS personnel identified the contract numbers in SPOT for these patients as non-DoD contracts, they did not bill for the health care provided. For the nine medical encounters for contractor personnel that worked under non-DoD contracts, DFAS personnel should have billed an additional \$21,476. DFAS personnel did not bill contractors that worked under non-DoD contracts because the DoD working group had not developed procedures to bill other Federal entities for their contractors who used MTFs.

Use of Databases That Were Not Intended for Billing and Data Input Errors Led to Reliability Problems

The data reliability issues with the billing system occurred because the DoD working group decided to use two databases, TMDS and SPOT, that were not intended for billing, and because staff at MTFs in Southwest Asia and contractor personnel made data input errors.

The primary purpose of TMDS is to collect, distribute, and view patient medical information rather than to bill. The purpose of SPOT is to serve as a central repository to track deployed contractor personnel supporting DoD military operations worldwide—again, not intended to be used for billing. DoD personnel might correct some of the database issues with simple fixes. For example, some of the TMDS electronic medical records contained the admission and discharge dates for the patient, but the TMDS spreadsheet used by DFAS personnel to bill contractors contained several medical

encounters that did not include a discharge date, resulting in underbilling the number of days.

Other database issues may require simple changes to the TMDS and SPOT systems or procedures to allow for identification and tracking of data not currently recorded. For instance, patients without social security numbers were assigned pseudo-social security numbers when they received treatment at an MTF in Southwest Asia, according to a TMDS expert. The pseudo-social security number was the patient's medical identification number in TMDS, but would not have traced to SPOT. Therefore, DFAS may not be able to bill contractor personnel without social security numbers for health care.

Similarly, the selections available in the patient category field in TMDS produce problems when used for billing. DoD staff did not always record a patient category in TMDS for contractor personnel seen at the MTF—the patient category was left blank in the electronic medical record. Also, DoD staff did not always choose contractor personnel as the patient category when more than one patient category was applicable. For example, some contractor personnel may have been retired U.S. military, which is an acceptable patient category in the electronic medical record. However, if the patient was also a contractor, but recorded as a U.S. military retiree, DFAS would not have billed the contractor organization for the health care provided.

In addition to database issues, data input errors existed. For example,

- The DoD staff in Southwest Asia did not always input the patient's name, social security number, date of birth, or patient category correctly in the medical record, which could affect the ability to bill.
- The DoD staff in Southwest Asia did not always input the exact date when the patient was discharged from the MTF in Southwest Asia and airlifted to Landstuhl Regional Medical Center in Germany for additional health care. This could cause DFAS to bill the contractor's organization incorrectly for the length of stay.
- Contractor personnel did not always input all their applicable data into SPOT, which would prevent DFAS from billing the contractor's organization.

Figure 4. An Aeromedical Evacuation at Kandahar Airfield, Afghanistan



Source: U.S. Air Force, January 5, 2011

Revisions Needed to Improve Billing Accuracy

If DoD continues billing using the current method, revisions are needed to improve data accuracy and to ensure that DoD bills for all contractor medical encounters. The USD(AT&L) should develop a quality control process to verify that contractor personnel consistently include applicable contract numbers in SPOT, including non-DoD contracts. Because of the wide range of problems affecting data integrity, the USD(C)/CFO, in coordination with the billing proponent, should develop a quality control process to improve the accuracy of data input into TMDS. The USD(C)/CFO should also closely examine the system in place and make any necessary adjustments to improve reliability of the data used for billing contractor health care. To include all contractor medical encounters, the ASD(HA) should provide DFAS with a TMDS spreadsheet that includes all patient categories except military personnel and all medical encounters where the patient category was left blank, and ASD(HA) should establish controls to ensure that all discharge dates are in the TMDS spreadsheet sent to DFAS for billing. Also, the USD(C)/CFO should develop procedures to bill for non-DoD contracts. Lastly, the USD(C)/CFO should bill contractors for the additional \$128,850 health care expenses identified in this report. If improvements to the billing system and the accuracy of data cannot be made, the proponent assigned should determine whether the current billing system is the best method to bill contractors.

Recommendations, Management Comments, and Our Response

B.1. We recommend that the Under Secretary of Defense for Acquisition, Technology, and Logistics, develop a quality control process to verify that contractor personnel consistently include applicable contract numbers in Synchronized Predeployment and Operational Tracker, to include non-DoD contracts.

Under Secretary of Defense for Acquisition, Technology, and Logistics Comments

The Assistant Secretary of Defense (Logistics and Materiel Readiness) provided comments for the USD(AT&L). He agreed and stated that a quality control process was already in place. The SPOT Program Management Office established a process to ensure that records were tagged for further research each time a database query returned a record where a contract number could not be identified.

Our Response

The Assistant Secretary's comments were responsive, and no additional comments were required.

B.2. We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, in coordination with the DoD working group and the functional proponent determined in response to Recommendation A.1:

a. Establish a quality control process to improve the data entry into the Theater Medical Data Store to accurately identify contractor personnel and admission and discharge dates.

b. Establish procedures to allow the Defense Finance and Accounting Service to bill for all contractor medical encounters, including but not limited to:

i. Contractor personnel working under non-DoD contracts, and

ii. Contractor personnel with no social security numbers.

c. Bill contractors for the additional \$128,850 health care expenses identified in this report.

d. Consider another billing method if improvements to the billing system and the accuracy of data cannot be made.

Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD, Comments

The Deputy Comptroller for Program/Budget provided comments for USD(C)/CFO. He generally agreed with the recommendation; however, he stated that it should be directed to the functional proponent determined in response to Recommendation A.1, in coordination with USD(AT&L), USD(C)/CFO, ASD(HA), DFAS, the Joint Staff, the Combatant Commanders, and Military Departments. In addition, he stated that USD(C)/CFO was not the appropriate functional lead for all of the recommendations listed under B.2.

The Deputy Comptroller agreed with B.2.a and stated that the functional proponent would need to work with ASD(HA) to ensure that appropriate data entry edit checks were in TMDS. Further, he stated that Military Services and Combatant Commanders should require in-theater personnel to have TMDS training, and they should emphasize accuracy of TMDS data entry.

For Recommendation B.2.b, the Deputy Comptroller agreed with B.2.b.i, but disagreed with B.2.b.ii. For B.2.b.i, he stated that establishing and implementing a process to bill for these encounters would require an extensive evaluation of interagency agreements across the U.S. Government. Further, he stated that, “[a]fter the designation of a functional proponent, this should be the next step for review and action.” For B.2.b.ii, the Deputy Comptroller stated that numerous changes had been made to improve the SPOT query process. The social security number was no longer a requirement to run a SPOT query from the TMDS data. Further, he stated that this recommendation should be removed since it was no longer an accurate statement of the process.

The Deputy Comptroller agreed with B.2.c and stated that the \$128,850 worth of health care expenses identified in the DoD OIG report would be part of efforts to bill for

services rendered in prior years. However, he disagreed with B.2.d and stated that DFAS used the systems available to implement the billing process as required by law. In addition, he asked that we clearly state in the report that there were no other systems available for meeting the overall billing objective. Further, he stated that the cost to develop a new system or method was unwarranted at this time.

Our Response

The Deputy Comptroller's comments were responsive to B.2.b.ii, B.2.c, and B.2.d and partially responsive to B.2.a and B.2.b.i.

We directed the recommendation to USD(C)/CFO because no DoD functional proponent had been established and USD(C)/CFO chairs the DoD working group for this area. Moreover, DoDI 3020.41, "Operational Contract Support," December 20, 2011, assigned USD(C)/CFO the responsibility for developing policy addressing the reimbursement of funds for qualifying medical support received by contingency contractor personnel in applicable contingency operations. We could not make the recommendation to a proponent that had not been designated.

The Deputy Comptroller's comments were partially responsive for Recommendations B.2.a and B.2.b.i. While there is no designated functional proponent, USD(C)/CFO should act as an interim proponent because it chairs the DoD working group and is responsible for developing policy, according to DoDI 3020.41. Therefore, we requested additional comments.

The Deputy Comptroller's comments were responsive for Recommendations B.2.b.ii, B.2.c, and B.2.d, and no additional comments were required. Although he disagreed with Recommendation B.2.b.ii, his comments were responsive because DFAS no longer requires the patient's social security number to bill for health care. We did not remove the recommendation from the report, as requested by the Deputy Comptroller, because it pertained to our review of the billings for February 2011, which identified a weakness in billing for patients without a social security number. The Deputy Comptroller also disagreed with Recommendation B.2.d; however, his comments were responsive because ASD(HA) made improvements to the billing system during our audit.

We agree with the Deputy Comptroller's comment that there are no other systems available for meeting the overall billing objective. However, we disagree that this is the only method for billing in Southwest Asia. Other methods for medical billing could include billing by coded medical encounters, applying capitation rates to contractors, having a cash collection voucher system (which is a method used at the MTF in Camp Bondsteel, Kosovo), and receiving cash for service (which is a method used by several commercial hospitals on military installations in Southwest Asia). However, as stated in our recommendation, other billing methods should be considered only if improvements to the billing system and the accuracy of data cannot be made. Since improvements have been made, we require no additional comments.

B.3. We recommend that the Assistant Secretary of Defense (Health Affairs):

a. Provide the Defense Finance and Accounting Service with Theater Medical Data Store spreadsheets that include all patient categories except military personnel and all medical encounters where the patient category was left blank to identify all contractor personnel that received reimbursable health care in Southwest Asia.

b. Establish a quality control process to include all discharge dates in the Theater Medical Data Store information sent to the Defense Finance and Accounting Service for billing.

Assistant Secretary of Defense (Health Affairs) Comments

The Chief Financial Officer, ASD(HA), provided comments for the ASD(HA). He agreed with Recommendation B.3.a and stated that the TMDS spreadsheet was updated in December 2011 in response to our Discussion Draft Report. The TMDS spreadsheet contained data for contractors where DoD staff left the patient category field blank and the Service field was “CTR.”

The Chief Financial Officer disagreed, however, with Recommendation B.3.b and stated that changes were made to the TMDS spreadsheet in December 2011 to include all discharge dates in TMDS in response to our Discussion Draft Report. He stated that there is a need to “establish a quality control process to include all discharge dates;” however, ASD(HA) believed the Services are responsible for carrying this out.

Our Response

The Chief Financial Officer’s comments were responsive, and no additional comments were required. Although he disagreed with Recommendation B.3.b, we believe that ASD(HA)’s actions met the intent of our recommendation.

According to DFAS officials, the TMDS spreadsheets from ASD(HA) have improved in listing the discharge date for contractor medical encounters. Further, this recommendation only addressed the accuracy of the spreadsheets that ASD(HA) officials provided to DFAS officials.

Appendix A. Scope and Methodology

We conducted this performance audit from November 2010 through January 2012 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

We contacted officials from the USD(AT&L), USD(C)/CFO, ASD(HA), Military Department Assistant Secretaries for Financial Management and Comptroller, USCENTCOM, the Joint Staff, the Military Department Surgeons General, DFAS, the U.S. Fleet Forces Command, and the U.S. Army Europe.

We reviewed public law, DoD policy, DoD memorandums, and USCENTCOM fragmentary orders to identify guidance about billing for health care provided to contractors at MTFs in Southwest Asia. Specifically, we reviewed Public Law 107-107, “National Defense Authorization Act for Fiscal Year 2002,” Section 1079b, “Procedures for Charging Fees for Care Provided to Civilians; Retention and Use of Fees Collected,” December 28, 2001; DoDI 3020.41, “Contractor Personnel Authorized to Accompany the U.S. Armed Forces,” October 3, 2005; DoDI 3020.41, “Operational Contract Support,” December 20, 2011; USD(C)/CFO memorandums from January 4, 2007; June 16, 2008; September 1, 2009; December 30, 2010; and March 29, 2012, “Medical Billing Rates for Other Than Foreign Military Personnel Utilizing Department of Defense Deployed/Non-Fixed Facilities;” and USCENTCOM Fragmentary Order 09-1038, “Contractor Care In the USCENTCOM [Area of Responsibility],” July 2006, updated September 15, 2010.

Before the billing implementation, we used statistical sampling procedures to determine the effectiveness of TMDS and SPOT for billing contractors in Southwest Asia. See Appendix C for detailed results on the statistical sample. Also, we used SPOT to determine whether the patient listed in the TMDS spreadsheets was a contractor, and whether we could trace the patient to a specific contract number. We compared the patients in our TMDS spreadsheets to SPOT to review the patients’ profiles, if present. We identified numerous patients listed in the TMDS spreadsheets as contractor personnel that were actually not contractor personnel, according to SPOT.

In May 2011, DFAS personnel provided the supporting documentation for the results from their contractor billings that began on April 29, 2011. We examined the 110 medical encounters billed by DFAS to determine whether DFAS billed the patient the correct amount for their visit and billed for all the contractor visits to MTFs in Southwest Asia. Additionally, we tested the reliability of the TMDS and SPOT spreadsheets DFAS used for billing. We reviewed the electronic medical records in TMDS for the 110 billed medical encounters. We performed searches on the TMDS and SPOT Web sites to compare with the spreadsheets that were provided to DFAS to identify any additional encounters not included on the spreadsheets.

Also, we reviewed the following documentation: the DoD working group summaries, electronic medical records in TMDS, scanned-in hardcopy inpatient medical records, the billing concept for billing contractors, business rules for billing contractors, and various e-mail correspondence between DoD Components.

During our final stages of report processing, on May 24, 2012, DFAS officials provided documentation supporting \$13.7 million for health care going back to FY 2007. We confirmed that the documentation supported the \$13.7 million; however, we did not verify the accuracy and completeness of the billings for health care going back to FY 2007.

Computer-Processed Data

We used computer-processed data obtained from TMDS and SPOT. Officials at ASD(HA) provided spreadsheets from TMDS that we used in our analysis. From the TMDS spreadsheets, we developed a spreadsheet, called “Known Population,” that contained FY 2010 inpatient and outpatient encounters listed with a “Duty Status” of “Other Beneficiaries of U.S. Government – Contract Employee.” We developed a second spreadsheet, called “Unknown Population,” that contained only FY 2010 inpatient and outpatient encounters having the following criteria:

- Duty Status listed as “Unknown or Other,”
- Service Description listed as “Unknown or Other,” or
- Rank Code listed as “UNK or OTHR.”

We tested the reliability of the TMDS spreadsheets by examining the electronic medical record in TMDS and, if available, the scanned hardcopy records obtained from the U.S. Army Medical Command, Patient Administration Systems and Biostatistics Activity. We encountered duplicate entries, overlapping stays, admission or discharge date discrepancies, and patients with multiple profiles. Therefore, we concluded that the data from the TMDS spreadsheets that we received from ASD(HA) were inaccurate.

However, we adjusted the information in the spreadsheets based on the errors identified from our review to determine what DoD should have billed for FY 2010. Specifically, we determined the amount that DoD should have billed for the sample encounter using the inpatient and outpatient rates with the correct information from the medical record. For any inpatient stay that was the result of an outpatient visit, we backed out the dollar amount of the outpatient visit. Also, we determined an amount that should have been billed for the sample encounter only if we were able to trace the patient to SPOT as being a contractor. Because we adjusted the data to remove the errors we identified, we believe that the data used for the calculation of potential monetary benefits were a conservative estimate and were sufficiently reliable for the purposes of our conclusion.

We did limited testing of the reliability of data from SPOT. We used the data in SPOT as a tool in our analysis of the billing concept to determine whether the data in the TMDS spreadsheets were reliable for determining whether the patient was actually a contractor.

In addition, we used SPOT to trace contractor personnel to contract numbers during our review of the April 2011 billings. Although we did not fully verify the accuracy of SPOT, we did identify SPOT inaccuracies/omissions, and we considered an encounter to be a missed opportunity to bill only if we had corroborating evidence that it was a contractor encounter. We did not use corroborating evidence for the Unknown Population TMDS spreadsheet because TMDS did not identify the medical encounters as contractor personnel.

Use of Technical Assistance

The DoD OIG Quantitative Methods Division assisted with the audit. See Appendix C for detailed information about the work the Division performed.

Prior Coverage

During the last 5 years, the DoD OIG has issued one report discussing medical care provided by MTFs to contractors in southwest Asia. Unrestricted DoD OIG reports can be accessed at <http://www.dodig.mil/audit/reports>.

DoD OIG

DoD OIG Report No. D-2009-078, “Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia,” May 4, 2009

Appendix B. Audit Request



UNITED STATES CENTRAL COMMAND
OFFICE OF THE COMMANDER
7115 SOUTH BOUNDARY BOULEVARD
MACDILL AIR FORCE BASE, FLORIDA 33621-5101

1 April 2009

Mr. Gordon S. Heddell
Acting Inspector General
Department of Defense
400 Army Navy Drive
Arlington, VA. 22202-4704

Dear Mr. Heddell,

The Department of Defense Inspector General (DODIG) remains a valued USCENTCOM partner in assessing critical mission areas and providing commanders necessary feedback on their operations. Because of your expertise, I am requesting your assistance once again regarding a concern in my area of responsibility.

Two recent DODIG draft reports cause me concern: "Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia (D2008-D000LF-0241.000) and "Contracting for Non-tactical Vehicles (NTVs) in Support of Operation Enduring Freedom (D2008-D000LH-0235.001). The health care report identified that "military treatment facilities may have provided healthcare billable in the millions without seeking reimbursement." Also, the NTV report indicated that "85 percent of 215 contract files did not contain documentation to show that contracting officers appointed contracting officers representatives to oversee the contracts".

I am requesting DODIG conduct a follow-up review of these inspections within six months of the release of the final reports.

I appreciate your assistance in these critical matters, as I have the utmost regard for DODIG's auditing and accountability functions.

Sincerely,

*Thanks for your great work.
You and your team have
been of invaluable assistance.*

DAVID H. PETRAEUS
General, U.S. Army
Commanding

Appendix C. Statistical Sample

With assistance from the Quantitative Methods Division, we used a statistical sample to project the following for FY 2010:

- the number of errors in the TMDS spreadsheet that could result in billing inaccuracies,
- the number of patients listed in the TMDS spreadsheet as contractor personnel without a contract number in SPOT,
- the number of patients listed in the TMDS spreadsheet with an unknown patient category, but identified as contractor personnel in SPOT, and
- the estimate of claims not billed for contractor health care provided by MTFs in Southwest Asia.

Population

The population consisted of two TMDS spreadsheets with inpatient and outpatient encounters for patients listed as contractors (Known population) and listed as unknown for their rank, patient category, or military service (Unknown population). The Known population consisted of 29,532 medical encounters, but we found that the Known population contained some patients listed as U.S. Government employees and contractors from the Joint Patient Tracking Application. Therefore, once we extracted those patients whose patient category was listed as contractor personnel and removed the duplicate line items from the spreadsheet, the inpatient strata consisted of 1,433 encounters and the outpatient strata consisted of 11,160 encounters, for a total of 12,593 medical encounters. The Unknown population consisted of 375,867 medical encounters. Once we removed the duplicates, the inpatient strata consisted of 506 encounters and the outpatient strata consisted of 164,532 encounters, for a total of 165,038 medical encounters.

Sample Plan

We used a stratified sampling design for this review. We stratified the Known and Unknown populations by inpatient and outpatient encounters and determined the appropriate sample size for each stratum based on our calculations, what-if analysis we performed, and our professional judgment. We drew samples without replacement from each stratum using the random function tool in Microsoft Excel. See Tables C-1 and C-2 for details of the strata and sample sizes used in the review.

Table C-1. Known Population for Medical Encounters, FY 2010

Stratum	Population Size	Sample Size
Inpatient	1,433	135
Outpatient	11,160	128
Total	12,593	263

Table C-2. Unknown Population for Medical Encounters, FY 2010

Stratum	Population Size	Sample Size
Inpatient	506	30
Outpatient	164,532	120
Total	165,038	150

Statistical Projection and Interpretation

In the paragraphs below, we detail our projections and interpretations for all four statistical projections made in the audit report.

Errors in TMDS Spreadsheet That Could Affect Billing

To determine the number of errors in the Known population that could result in billing inaccuracies if TMDS was used for billing, we compared the sampled medical encounters in the TMDS spreadsheet to the corresponding patient's electronic medical record or the patient's hardcopy medical record from the U.S. Army Patient Administration Systems and Biostatistics Activity. Based on our review of the sampled encounters, we calculated the projection at the 90-percent confidence level. See Table C-3.

Table C-3. Statistical Projections of Known Population Results for TMDS Line Item Errors That Could Affect Billing, FY 2010

	Lower Bound	Point Estimate	Upper Bound
TMDS Line Item contained an error that could affect billing	2,726 21.6 percent	3,499 27.8 percent	4,272 33.9 percent

From the population of 12,593 medical encounters, we are 90-percent confident that the number of medical encounters that had errors that could adversely affect billing using TMDS was between 2,726 and 4,272 medical encounters, and the error rate was between 21.6 percent and 33.9 percent. The point estimate was 3,499 medical encounters that had errors that could adversely affect billing by TMDS, or 27.8 percent.

Contractor Personnel That Did Not Have a Contract Number in SPOT

To determine the number of patients listed in the Known population that did not have a contract number in SPOT, we entered the patient's name from the corresponding sampled medical encounters in the TMDS spreadsheet into SPOT to view the patient's SPOT profile, if present. Based on our review, we calculated the projection at the 90-percent confidence level. See Table C-4.

Table C-4. Statistical Projections of Known Population for the Number of Contractor Personnel That Did Not Have a Contract Number in SPOT, FY 2010

	Lower Bound	Point Estimate	Upper Bound
Patient's contract number was not identified in SPOT – contractor organization could not be billed for patient's visit	4,486 38.6 percent	5,285 45.3 percent	6,084 51.9 percent

From the population of 12,593 medical encounters, we are 90-percent confident that the number of medical encounters that would not trace to a corresponding contract organization that could be billed by DoD for their employee's medical care visit was between 4,486 and 6,084 medical encounters, and the error rate was between 38.6 percent and 51.9 percent. The point estimate was 5,285 medical encounters that could not be billed by DFAS, or 45.3 percent, because SPOT did not contain the patient's contract number.

Estimated Number of Contractor Personnel Not Identified as Contractor Personnel in TMDS

To determine the number of patients listed in the Unknown population that are actually contractor personnel in SPOT, we entered the patient's name from the corresponding sampled medical encounters in the TMDS spreadsheet into SPOT to view the patient's SPOT profile, if present. If the patient was identified in SPOT as contractor personnel, we counted that medical encounter as a potentially billable event. Based on our review, we calculated the projection at the 90-percent confidence level. See Table C-5.

Table C-5. Statistical Projections of Unknown Population Results for the Number of Medical Encounters That Are Contractor Personnel Visits, FY 2010

	Lower Bound	Point Estimate	Upper Bound
The patient was identified as contractor personnel in SPOT	3,705 2.2 percent	11,019 6.7 percent	18,334 11.1 percent

From the Unknown population of 165,038 medical encounters, we are 90-percent confident that the number of medical encounters for contractor personnel that received medical care at an MTF in Southwest Asia was between 3,705 and 18,334 medical encounters, or between 2.2 percent and 11.1 percent. The point estimate was 11,019 medical encounters that were contractor personnel that received medical care at an MTF in Southwest Asia, or 6.7 percent.

Estimate of Claims Not Billed for Contractor Health Care

To determine the estimate of claims not billed for contractor health care provided by MTFs in Southwest Asia, we calculated the billable amount for every contractor personnel medical encounter in the Known and Unknown sample that we were able to trace to SPOT as a contractor. Based on our review, we calculated the projection at the 90-percent confidence level. See Table C-6.

Table C-6. Estimate of Claims Not Billed for Health Care Provided by MTFs to Contractors in Southwest Asia, FY 2010

	Lower Bound	Point Estimate	Upper Bound
Amount	\$6,691,152	\$8,107,341	\$9,523,530

For the dollar projection, we are 90-percent confident that the contractor billings were between \$6,691,152 and \$9,523,530, with a point estimate of \$8,107,341. Therefore, we project that the FY 2010 estimate of claims not billed for contractor health care was at least \$8.1 million when you combine the point estimates for the Known and Unknown projections. These projections did not take into account medical encounters in TMDS where the patient category was left blank or the contractor medical encounters from TMDS that did not trace to SPOT as a contractor. Therefore, we believe our dollar projections were conservative.

Appendix D. Summary of Potential Monetary Benefits

Recommendation	Type of Benefit	Amount of Benefit	Account
A.2	Economy and Efficiency. Billing for prior health care provided by MTFs to contractors in Southwest Asia would provide additional resources to support the troops.	Funds put to better use: \$13.7 million, as of May 24, 2012. This amount represents additional funds available to the Military Departments. We plan to track that amount and any additional billings using our audit followup process.	Army 2122020.0000 8A 2024P135197.0000 2566 832QMR 2QMR83 S09076 Navy AA1721804.0000 60BA260000602 0609512DV68684 686841K7000T Air Force 5723400.0000 301 7826 W0X040 01 559ZZ 28539F ESP 7C S667100
B.2	Internal Controls. Improving the quality controls on the current billing system would reduce the amount underbilled and identify additional medical encounters to be billed.	Undeterminable. Amount is subject to results of future billings by DFAS for health care provided by MTFs to contractors in Southwest Asia. We plan to track monetary benefits during the audit followup process. Determinable. Funds put to better use: \$128,850 for underbilled amount for February 2011 contractor health care addressed in Recommendation B.2.c.	Army 2122020.0000 8A 2024P135197.0000 2566 832QMR 2QMR83 S09076 Navy AA1721804.0000 60BA260000602 0609512DV68684 686841K7000T Air Force 5723400.0000 301 7826 W0X040 01 559ZZ 28539F ESP 7C S667100

Under Secretary of Defense for Acquisition, Technology, and Logistics Comments



LOGISTICS AND
MATERIEL READINESS

ASSISTANT SECRETARY OF DEFENSE

3500 DEFENSE PENTAGON
WASHINGTON, DC 20301-3500

MAR 16 2012

MEMORANDUM FOR ASSISTANT INSPECTOR GENERAL AND DIRECTOR, DEFENSE
FINANCIAL AUDITING SERVICE, DEPARTMENT OF
DEFENSE INSPECTOR GENERAL (DODIG)

THROUGH: DIRECTOR, ACQUISITION RESOURCES AND ANALYSIS

78
3/19/12

SUBJECT: Response to DoDIG Draft Report on the Billing System for Health Care Provided to
Contractors at Medical Treatment Facilities in Southwest Asia (Project No. D2011-
D000LF-0041.000)

As requested by your February 1, 2012 memorandum "DoD Needs to Improve the Billing Systems for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia," I am providing responses to the two recommendations for the Under Secretary of Defense for Acquisition, Technology, and Logistics (USD(AT&L)) contained in the subject draft report.

Recommendation A1:

That the Under Secretary of Defense (Comptroller)/Chief Financial Officer, chair a meeting with the USD(AT&L) and the Under Secretary of Defense for Personnel and Readiness to select a DoD functional proponent responsible for overseeing the billing system for health care provided to contractor personnel authorized to accompany U.S. Armed Forces in contingency operations.

Response:

Concur. We agree a single DoD functional component responsible for overseeing the billing process is necessary. The Defense Finance and Accounting Service (DFAS) currently serves as the functional proponent for the Military Services and DoD Components accounting and billing functions. The Department maintains multiple regulatory requirements that outline specific requirements for billings and collections. As such, those guidelines are incorporated into the services that DFAS provides.

A comprehensive DoD working group was established in the Fall of 2008 to collaboratively identify improvements to the medical billing process. Membership includes all Military Services (both foreign military sales and medical communities), Joint Staff, OUSD(AT&L), Office of General Counsel (Fiscal), U.S. Central Command, OASD(Health Affairs), DFAS, and OUSD(Comptroller)/PB. The working group continues to review roles and responsibilities associated with the billing system process for in-theater health care provided to contractor personnel and will further assign specific oversight responsibilities to the most appropriate organization.

Recommendation B1:

That the Under Secretary of Defense for Acquisition, Technology, and Logistics develop a quality control process to verify that contractor personnel consistently include applicable contract numbers in Synchronized Predeployment and Operational Tracker (SPOT), to include non-DoD contracts.

Response:

Concur. A quality control process is already in place. SPOT requires all users enter a contract number into the system for a valid record to be created. Therefore, any valid record in SPOT includes a contract number. In addition, the SPOT Program Management Office established a process to ensure records are tagged for further research each time a database query returns a record where a contract number cannot be identified. In these rare cases, with some additional research, our analysis has concluded a contract number can be found and provided to the DFAS for billing.

Please contact [REDACTED], [REDACTED], [REDACTED] if additional information is required.



Alan F. Estevez

Under Secretary of Defense (Comptroller)/Chief Financial Officer, DoD Comments



COMPTROLLER
(Program/Budget)

OFFICE OF THE UNDER SECRETARY OF DEFENSE
1100 DEFENSE PENTAGON
WASHINGTON, DC 20301-1100

MAF - 9 2012

MEMORANDUM FOR INSPECTOR GENERAL OF THE DEPARTMENT OF DEFENSE

SUBJECT: Draft Report, "Health Care Provided by Military Treatment Facilities to Contractors in Southwest Asia" (Project No. D2011-D000LF-0041.000)

Thank you for the opportunity to review and provide comments on the subject draft report, dated February 2, 2012. While we generally agree that additional improvements can and are being made to the billing process, our specific comments/concerns on the draft report are provided in the attached document. My point of contact is [REDACTED], who may be reached at [REDACTED].

A handwritten signature in black ink, appearing to read "John P. Roth", is located above the printed name.

John P. Roth
Deputy Comptroller

Attachment:
As stated

**DEPARTMENT OF DEFENSE OFFICE OF THE INSPECTOR GENERAL
DRAFT REPORT – DATED FEBRUARY 1, 2012
PROJECT NO. D2011-D000LF-0041.000**

**“DOD NEEDS TO IMPROVE BILLING SYSTEMS FOR HEALTH CARE
PROVIDED TO CONTRACTORS AT MEDICAL TREATMENT FACILITIES IN
SOUTHWEST ASIA”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATIONS**

Recommendation A.1, (page 6): We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, chair a meeting with the Under Secretary of Defense for Acquisition, Technology, and Logistics and the Under Secretary of Defense for Personnel and Readiness to select a DoD functional proponent responsible for overseeing the billing system for health care provided to contractor personnel authorized to accompany U.S. Armed Forces in contingency operations.

DoD Response: Partially concur. The Defense Finance and Accounting Service (DFAS) continues to serve as the functional proponent for DoD accounting/billing functions. The DoD working group continues to review roles and responsibilities in terms of specific oversight billing system for in-theater health care provided to contractor personnel and plans to assign oversight responsibilities to the most appropriate organization during the Department’s upcoming Program/Budget Review.

Recommendation A.2, (page 6): We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, in coordination with the proponent selected in response to Recommendation A.1., bill contractors for health care provided in Southwest Asia before February 2011.

DoD Response: Concur. The DFAS has billed for medical treatment events going back to Fiscal Year (FY) 2007, and continues to address data integrity issues for additional billings. Although the initial billings are not complete, DFAS continues to work with the Synchronized Pre-Deployed Operational Tracker (SPOT) and the Theater Medical Data Store (TMDS) to align medical treatment events to primary contractors for additional billings. Numerous changes have been made to improve the SPOT query process by 10 percent to include identifying contracts whether or not they have a task order associated with them; running queries on all active, open or closed SPOT deployments; and opening up the query to include Social Security Number (SSN, Last Name/First Name and Date of Birth.) The report indicates in the above statement that billings prior to February 2011 need to occur. We are actively billing for medical treatment events going back to FY 2007. The report should acknowledge the organizations involved in these billings activities, and recognize the progress made by these organizations.

Recommendation B.2, (page 13): We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, in coordination with the DoD working group and the proponent determined in response to Recommendation A.1:

DoD Response: Nonconcur. Recommend initial statement be revised to read:

“We recommend that the proponent determined in response to Recommendation A.1, in coordination with the appropriate organizations to include, the Under Secretary of Defense (Comptroller)/Chief Financial Officer; the Under Secretary of Defense for Acquisition, Technology, and Logistics; the Assistant Secretary of Defense (ASD) (Health Affairs); the Defense Finance and Accounting Service; the Joint Staff; the Combatant Commander; and Military Departments.”

The Under Secretary of Defense (Comptroller)/Chief Financial Officer is not the appropriate functional lead for all of the recommendations listed under B.2, nor is the “DoD working group” an appropriate entity to assign specific tasks. Therefore, this recommendation should list the specific organizations that comprise the working group.

Recommendation B.2.a, (page 13): Establish a quality control process to improve the data entry into the Theater Medical Data Store to accurately identify contractor personnel and admission and discharge dates.

DoD Response: Concur. The proponent determined in response to Recommendation A.1 will need to work with ASD(Heath Affairs) who owns and manages Theater Medical Data Store (TMDS) to ensure appropriate data entry edits checks are in place within the system. Also requires TMDS training and emphasis on accuracy by Military Services and Combatant Commanders to in-theater personnel.

Recommendation B.2.b, (page 13): Establish procedures to allow the Defense Finance and Accounting Service to bill for all contractor medical encounters, including but not limited to:

- i. Contractor personnel working under non-DoD contracts
- ii. Contractor personnel with no social security numbers.

DoD Response: Concur with the B.2.b.i. recommendation. The initial billing process has concentrated on capturing, billing, and improving the data collection for care related to DoD controlled contracts, which make up an estimated 98 percent of the in-theater health care provided to contractors. While billing for care provided to non-DoD contractors is certainly a long-term goal of the process, establishing and implementing a process to bill for these encounters will require an extensive evaluation of interagency agreements across the United States Government. After the designation of a functional proponent, this should be the next step for review and action.

Nonconcur with the B.2.b.ii. recommendation. This effort is already occurring. The DFAS continues to work with SPOT and TMDS to DoD align medical treatment events to primary contractors for additional billings. Numerous changes have been made to improve the SPOT

query process to include identifying contracts whether or not they have a task order associated with them; running queries on all active, open or closed SPOT deployments; and opening up the query to include SSN, or if no SSN exists, then Last Name/First Name and Date of Birth (DOB). A review of the SPOT query for the December 2011 and January 2012 TMDS data, results in contract data being provided for all personnel properly identified in SPOT and having a record as a "contractor personnel." When the query result states that there is no data in SPOT on an individual, it is either because they have been improperly coded in TMDS as a contractor personnel and they are truly a government civilian or the name and DOB provided by TMDS does not have enough fidelity to create a match in SPOT (e.g. First Name: Trauma; Last Name: Doe; with a DOB that is made-up). The SSN is no longer a requirement in order to run a SPOT query from the TMDS data. This recommendation should be removed since it is not an accurate statement of the process.

Recommendation B.2.c, (page 13): Bill contractors for the additional \$128,850 health care expenses identified in this report.

DoD Response: Concur. The \$128,850 worth of health care expenses identified in the Inspector General report will be part of efforts to bill for services rendered in prior years.

Recommendation B.2.d, (page 13): Consider another billing method if improvements to the billing system and the accuracy of data cannot be made.

DoD Response: Nonconcur. The DFAS utilized the systems available to implement the billings process as required by law. The report indicates that "non-financial" systems were selected that were not established as sources for billing contractors. It is recommended the report clearly state that there were no other systems available for meeting the overall billing objective. The Department continues to refine and improve both the billing system and the accuracy of the data currently in use and believes that the cost to develop a new system/method is unwarranted at this time.

Other Comment

Audit Statement (pages i and 6): "We estimate DoD did not bill contractors for at least \$8.1 million in health care expenses for FY 2010."

DoD Response: Nonconcur. The Defense Finance and Accounting Service has billed for \$4.2 million in FY 2010 contractor health care encounters and continues to review data to determine if additional billings are required.

Assistant Secretary of Defense (Health Affairs) Comments



OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE HEALTH AFFAIRS

SKYLINE FIVE, SUITE 810, 5111 LEESBURG PIKE
FALLS CHURCH, VIRGINIA 22041-3206

TRICARE
MANAGEMENT
ACTIVITY

MAR - 7 2012

MEMORANDUM FOR DEPARTMENT OF DEFENSE INSPECTOR GENERAL
PROGRAM DIRECTOR, MILITARY HEALTH SYSTEM
DIVISION

SUBJECT: Department of Defense Inspector General Draft Report "Department of Defense Needs to Improve the Billing System for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia" (Project No. D2011-D000LF-0041.000)

Thank you for the opportunity to review and comment on the Department of Defense draft report Project No. D2011-D000LF-0041.000 - "DoD Needs to Improve the Billing System for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia," dated February 1, 2012.

My specific comments to Recommendations A.1, 3a and 3b are attached. Recommendation 3b was assigned to the Office of the Assistant Secretary of Defense (Health Affairs)) for action but belongs to the functional POC which is your office. Please feel free to utilize our comments on this recommendation to help formulate your response. Overall, I concur with the report's findings and conclusions.

Please feel free to direct any comments to my action officers on this topic, [REDACTED]

[REDACTED] (Functional) at [REDACTED] or [REDACTED] (Audit Liaison) at [REDACTED]


Allen W. Middleton, SES
Chief Financial Officer
Office of the Chief Financial Officer

Attachment:
As stated

**DEPARTMENT OF DEFENSE OFFICE OF THE INSPECTOR GENERAL
DRAFT REPORT – DATED FEBRUARY 1, 2012
PROJECT NO. D2011-D000LF-0041.000
“DOD NEEDS TO IMPROVE BILLING SYSTEMS FOR HEALTH CARE
PROVIDED TO CONTRACTORS AT MEDICAL TREATMENT
FACILITIES IN SOUTHWEST ASIA”**

**DEPARTMENT OF DEFENSE COMMENTS
TO THE RECOMMENDATIONS**

We recommend that the Assistant Secretary of Defense (Health Affairs):

RECOMMENDATION A.1: We recommend that the Under Secretary of Defense (Comptroller)/Chief Financial Officer, chair a meeting with the Under Secretary of Defense for Acquisition, Technology, and Logistics and the Under Secretary of Defense for Personnel and Readiness to select a Department of Defense (DoD) functional proponent responsible for overseeing the billing system for health care provided to contractor personnel authorized to accompany U.S. Armed Forces in contingency operations.

DOD RESPONSE: Concur. The Defense Finance and Accounting Service (DFAS) continues to serve as the functional proponent for DoD accounting/billing functions. The DoD working group continues to review roles and responsibilities in terms of specific oversight of the billing system for in-theater health care provided to contractor personnel. The Working Group plans to assign oversight responsibilities to the most appropriate organization during the Department's upcoming Program and Budget Review.

RECOMMENDATION B.3.a: Provide the Defense Finance and Accounting Service with Theater Medical Data Store spreadsheets that include all patient categories except military personnel and all medical encounters where the patient category was left blank to identify all contractor personnel that received reimbursable health care in Southwest Asia.

DOD RESPONSE: Concur. The Theater Medical Data Store (TMDS) spreadsheet was updated in December 2011 in response to the DoD IG Discussion Draft Report, "DoD Needs to Improve the Billing System for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia", October 31, 2011. The TMDS spreadsheet contains data for contractors based on the following patient category codes: A03-Contractor, K65 -Other Beneficiaries of U.S. Government - Contract Employee, K99-Patients Not Elsewhere Classified-Other, X60-Foreign National-Civilian Contractor OCONUS in Support of DoD Operation, X65-U.S. Citizen-Civilian Contractor OCONUS in Support of DoD Operation. The spreadsheet also includes data for those entries where

the patient category field is left blank ("NULL" selection) and the Service field is "CTR". The spreadsheet excludes all other patient categories.

RECOMMENDATION B.3.b: Establish a quality control process to include all discharge dates in the Theater Medical Data Store information sent to the Defense Finance and Accounting Service for billing.

DOD RESPONSE: Non-concur. The program office updated the TMDS spreadsheet in December 2011 to include all discharge dates in TMDS in response to the DoD IG Discussion Draft Report, "DoD Needs to Improve the Billing System for Health Care Provided to Contractors at Medical Treatment Facilities in Southwest Asia", October 31, 2011. We agree that there is a need to "establish a quality control process to include all discharge dates"; however, the Services, not the program office, are responsible for carrying this out. The program office is responsible for developing the TMDS system for operational use by the Services.



Inspector General Department of Defense